[THIS VERSION OF THE REPORT IS MADE AVAILABLE IN ACCORDANCE WITH CIC SECTION 12938]

REPORT OF THE MARKET CONDUCT EXAMINATION

OF THE CLAIMS PRACTICES OF THE

GLOBE LIFE AND ACCIDENT INSURANCE COMPANY
NAIC # 91472 CDI # 2439-8
AMERICAN INCOME LIFE INSURANCE COMPANY
NAIC # 60577 CDI # 1908-3
LIBERTY NATIONAL LIFE INSURANCE COMPANY
NAIC# 65331 CDI# 1679-0
UNITED AMERICAN INSURANCE COMPANY
NAIC #92916 CDI# 2505-6
UNITED INVESTORS LIFE INSURANCE COMPANY
NAIC# 94099 CDI# 2493-5

AS OF JULY 15, 2006

ADOPTED ON November 12, 2008

STATE OF CALIFORNIA

DEPARTMENT OF INSURANCE

MARKET CONDUCT DIVISION

FIELD CLAIMS BUREAU

Format 12938

NOTICE REGARDING CONFIDENTIALITY

The provisions of Section 735.5(a) (b) and (c) of the California Insurance Code describe the Commissioner's authority and exercise of discretion in the use and/or publication of any final or preliminary examination report or other associated documents. Section 12938 of the California Insurance Code requires the publication of certain legal documents and examination reports.

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DEPARTMENT OF INSURANCE
Consumer Services and Market Conduct Branch
Field Claims Bureau, 11th Floor
300 South Spring Street
Los Angeles, CA 90013

November 12, 2008

The Honorable Steve Poizner
Insurance Commissioner
State of California
45 Fremont Street
San Francisco, California 94105

Honorable Commissioner:

Pursuant to instructions, and under the authority granted under Part 2, Chapter 1, Article 4, Sections 730, 733, 736, and Article 6.5, Section 790.04 of the California Insurance Code; and Title 10, Chapter 5, Subchapter 7.5, Section 2695.3(a) of the California Code of Regulations, an examination was made of the claims practices and procedures in California of:

Globe Life and Accident Insurance Company
NAIC # 91472
American Income Life Insurance Company
NAIC # 60577
Liberty National Life Insurance Company
NAIC# 65331
United American Insurance Company
NAIC #92916
United Investors Life Insurance Company
NAIC# 94099

Group NAIC # 0290

Hereinafter, the Companies listed above also will be referred to as GLAIC, AILIC, LNLIC, UAIC, UILIC, or the Company or, collectively, as the Companies.

This report is made available for public inspection and is published on the California Department of Insurance web site (www.insurance.ca.gov) pursuant to California Insurance Code section 12938.

FOREWORD

The examination covered the claims handling practices of the aforementioned Companies during the period July 16, 2005, through July 15, 2006. The examination was made to discover, in general, if these and other operating procedures of the Companies conform to the contractual obligations in the policy forms, the California Insurance Code (CIC), the California Code of Regulations (CCR) and case law. This report contains alleged violations of Section 790.03 and Title 10, California Code of Regulations, Section 2695 et al. The alleged violations of other relevant laws which resulted from this examination are included in a separate report.

The report is written in a "report by exception" format. The report does not present a comprehensive overview of the subject insurer's practices. The report contains a summary of pertinent information about the lines of business examined, details of the non-compliant or problematic activities that were discovered during the course of the examination and the insurer's proposals for correcting the deficiencies. When a violation that resulted in an underpayment to the claimant is discovered and the insurer corrects the underpayment, the additional amount paid is identified as a recovery in this report. All unacceptable or non-compliant activities may not have been discovered. Failure to identify, comment upon or criticize non-compliant practices in this state or other jurisdictions does not constitute acceptance of such practices.

Alleged violations identified in this report, any criticisms of practices and the Companies' responses, if any, have not undergone a formal administrative or judicial process.

SCOPE OF THE EXAMINATION

To accomplish the foregoing, the examination included:

1. A review of the guidelines, procedures, training plans and forms adopted by the Companies for use in California including any documentation maintained by the Companies in support of positions or interpretations of fair claims settlement practices.

2. A review of the application of such guidelines, procedures, and forms, by means of an examination of a sample of individual claims files and related records.

3. A review of the California Department of Insurance's (CDI) consumer complaints and inquiries about these Companies handled by the CDI during the same time period and a review of previous CDI market conduct examination reports on these Companies.

The review of the sample of individual claims files was conducted at the offices of the Companies in Oklahoma City, Oklahoma, McKinney, Texas, and Waco, Texas.

EXECUTIVE SUMMARY OF CLAIMS SAMPLE REVIEWED

The claims reviewed were closed from July 16, 2005 and July 15, 2006, referred to as the "review period". The examiners randomly selected 51 GLAIC claims files, 4 LNLIC claims files, 297 UAIC claims files, 22 UILIC claims files, and 300 AILIC claims files for examination. The examiners cited 501 alleged claims handling violations of the Fair Claims Settlement Practices Regulations and/or California Insurance Code Section 790.03 from this sample file review.

Findings within the scope of this report included: failure to provide an explanation of benefit with claim payment; failure to include a written basis for the denial; failure to include a statement in the written denial advising the claimant that he or she may have the matter reviewed by the California Department of Insurance; failure to disclose benefits that may apply to the claim presented; attempting to settle a claim by making a settlement offer that was unreasonably low; failure to investigate and failure to effectuate prompt, fair, equitable settlement of a claim.

RESULTS OF REVIEWS OF CONSUMER COMPLAINTS AND INQUIRIES, AND PREVIOUS EXAMINATIONS

The Companies were the subject of 20 California consumer complaints and inquiries closed between July 16, 2005 and July 16, 2006 in regard to the line of business reviewed in this examination. The review showed alleged non-compliance with respect to the following: failure to provide written notice of the need for additional time every 30 calendar days to determine whether a claims should be accepted or denied, failure to include a statement in its claim denial that, if the claimant believes the claim has been wrongfully denied or rejected, he or she may have the matter reviewed by the California Department of Insurance, failure to begin investigation and provide necessary forms, instructions, and reasonable assistance within 15 calendar days upon receiving notice of claim, failure to accept or deny the claim within 40 calendar days upon receipt of proof of claim and failure to respond to Department of Insurance claim inquiries within 21 calendar days of receipt of such inquiry. The Examiners focused on these issues during the course of the file review.

The previous claims examination reviewed a period from April 1, 2001 through March 31, 2002. The most significant noncompliance issues identified in the previous examination report were: failure to provide an explanation of benefit, failure to provide written basis for the denial of a claim, failure to advise the claimant that he or she may have the claim denial reviewed by the California Department of Insurance and failure to provide written notice of the need for additional time every 30 calendar days to determine whether a claims should be accepted or denied. These issues were identified as problematic in the current examination.

DETAILS OF THE CURRENT EXAMINATION

Further details with respect to the examination and alleged violations are provided in the following tables and summaries:

GLAIC SAMPLE FILES REVIEW			
LINE OF BUSINESS / CATEGORY	**CLAIMS FOR REVIEW PERIOD**	**SAMPLE FILES REVIEWED**	**CITATIONS**
Life/ Individual Life	1,107	27	3
Accident and Disability/Individual Cancer	7	7	8
Accident and Disability/Individual Hospital	17	1	1
Accident and Disability /Individual Medicare Supplement	409	7	1
Accident and Disability / Group Medicare Supplement	1,222	9	2
General Business Practices	-	-	1
TOTALS	2,762	51	16

LNLIC SAMPLE FILES REVIEW			
LINE OF BUSINESS / CATEGORY	**CLAIMS FOR REVIEW PERIOD**	**SAMPLE FILES REVIEWED**	**CITATIONS**
Life/ Individual Life	173	4	0
TOTALS	173	4	0

UAIC SAMPLE FILES REVIEW			
LINE OF BUSINESS / CATEGORY	**CLAIMS FOR REVIEW PERIOD**	**SAMPLE FILES REVIEWED**	**CITATIONS**
Life / Individual Life	276	7	0
Accident and Disability/ Individual Cancer	14	14	6
Accident and Disability/Individual Medical	1,074	64	14
Accident and Disability/ Individual Hospital	2,258	65	85
Accident and Disability/ Individual Surgical	66	34	3
Accident and Disability/ Individual Indemnity	7	6	13
Accident and Disability/ Individual Disability	2	2	0
Accident and Disability/ Individual Long-Term Care	487	60	146
Accident and Disability/ Individual Medicare Supplement	444,568	23	4
Accident and Disability/ Group Medicare Supplement	28,687	22	0
TOTALS	477,439	297	271

UILIC SAMPLE FILES REVIEW			
LINE OF BUSINESS / CATEGORY	**CLAIMS FOR REVIEW PERIOD**	**SAMPLE FILES REVIEWED**	**CITATIONS**
Life/ Individual Life	96	2	0
Annuities/ Individual Annuities	39	20	2
TOTALS	135	22	2

AILIC SAMPLE FILES REVIEW			
LINE OF BUSINESS / CATEGORY	**CLAIMS FOR REVIEW PERIOD**	**SAMPLE FILES REVIEWED**	**CITATIONS**
Life/ Individual Life	810	39	2
Annuities/ Individual Annuities	3	3	1
Accident and Disability/ Individual Income Disability	12	11	13
Accident and Disability/ Individual Accident and Sickness	1,596	65	12
Accident and Disability/ Individual Cancer	266	54	62
Accident and Disability/ Individual Surgical	42	26	89
Accident and Disability/ Individual Indemnity	63	33	32
Accident and Disability/ Individual Medicare Supplement	3,245	6	1
Life/ Group Life	38	20	0
Life/ Group Accident Death & Dismemberment	120	43	0
TOTALS	6,195	300	212

TABLE OF TOTAL CITATIONS

Citation	Description	GLAIC	LNLIC	UAIC	UILIC	AILIC
CCR §2695.11(b)	The Company failed to provide an explanation of benefits.	1	0	76	1	52
CCR §2695.7(b)(3)	The Company failed to include a statement in its claim denial that, if the claimant believes the claim has been wrongfully denied or rejected, he or she may have the matter reviewed by the California Department of Insurance.	4	0	53	0	30
CCR §2695.4(a)	The Company failed to disclose all benefits, coverage, time limits or other provisions of the insurance policy.	2	0	41	0	57
CCR §2695.7(b)(1)	The Company failed to provide the written basis for the denial of the claim.	2	0	60	0	23
CCR §2695.7(g)	The Company attempted to settle a claim by making a settlement offer that was unreasonably low.	1	0	4	0	27
CIC §790.03(h)(5)	The Company failed to effectuate prompt, fair and equitable settlements of claims in which liability had become reasonably clear.	1	0	23	0	2
CCR §2695.3(a)	The Company failed to maintain all documents, notes and work papers in the claim file.	1	0	11	0	3
CIC §790.03(h)(3)	The Company failed to adopt and implement reasonable standards for the prompt investigation and processing of claims arising under its insurance policies.	0	0	1	1	4
CCR §2695.7(d)	The Company failed to conduct and diligently pursue a thorough, fair and objective investigation of a claim.	0	0	0	0	5
CIC §790.03(h)(1)	The Company failed to represent correctly to claimants, pertinent facts or insurance policy provisions relating to a coverage at issue.	1	0	2	0	1
CCR §2695.5(e)(2)	The Company failed to provide necessary forms, instructions, and reasonable assistance within 15 calendar days.	0	0	0	0	3

TABLE OF TOTAL CITATIONS						
Citation	**Description**	**GLAIC**	**LNLIC**	**UAIC**	**UILIC**	**AILIC**
CCR §2695.7(h)	The Company failed, upon acceptance of the claim, to tender payment within 30 calendar days.	0	0	0	0	2
CCR §2695.7(c)(1)	The Company failed to provide written notice of the need for additional time every 30 calendar days.	1	0	0	0	1
CCR §2695.3(b)(1)	The Company failed to maintain claim data that are accessible, legible and retrievable for examination.	0	0	0	0	1
CCR §2695.7(b)	The Company failed, upon receiving proof of claim, to accept or deny the claim within 40 calendar days.	1	0	0	0	0
CCR §2695.5(b)	The Company failed to respond to communications within 15 calendar days.	0	0	0	0	1
Total Citations		**15**	**0**	**271**	**2**	**212**

TABLE OF TOTAL CITATIONS General Business Practices		
Citation	**Description**	**COMPANIES**
CCR §2695.6(b)	The Company failed to provide thorough and adequate training regarding these regulations to all its claims agents.	1
Total Citations		**1**

TABLE OF CITATIONS BY LINE OF BUSINESS

LIFE **2006 AILIC Written Premium: $ 40,665,299** **2006 GLAIC Written Premium: $32,128,536** **2006 UAIC Written Premium: $11,723,608** **2006 LNLIC Written Premium: $10,263,914** **2006 UILIC Written Premium: $2,251,509** **AMOUNT OF RECOVERIES $0**	**NUMBER OF CITATIONS**
CCR §2695.7(c)(1)	2
CCR §2695.7(b)	1
CCR §2695.3(a)	1
CIC §790.03(h)(3)	1
SUBTOTAL	**5**

ANNUITIES **2006 AILIC Written Premium: $ 657** **2006 GLAIC Written Premium: $1,089** **2006 UAIC Written Premium: $101,945** **2006 LNLIC Written Premium: $1,788** **2006 UILIC Written Premium: $30,213** **AMOUNT OF RECOVERIES $ 0**	**NUMBER OF CITATIONS**
CCR §2695.5(e)(2)	1
CCR §2695.11(b)	1
CIC §790.03(h)(3)	1
SUBTOTAL	**3**

ACCIDENT AND DISABILITY 2006 AILIC Written Premium: $ 4,926,653 2006 GLAIC Written Premium: $2,986,358 2006 UAIC Written Premium: $51,527,101 2006 LNLIC Written Premium: $84,312 2006 UILIC Written Premium: $0 AMOUNT OF RECOVERIES $ 20,234.00	NUMBER OF CITATIONS
CCR §2695.11(b)	129
CCR §2695.4(a)	100
CCR §2695.7(b)(3)	87
CCR §2695.7(b)(1)	85
CCR §2695.7(g)	32
CIC §790.03(h)(5)	26
CCR §2695.3(a)	14
CIC §790.03(h)(3)	4
CCR §2695.7(d)	5
CIC §790.03(h)(1)	4
CCR §2695.5(e)(2)	2
CCR §2695.7(h)	2
CCR §2695.3(b)(1)	1
CCR §2695.5(b)	1
SUBTOTAL	**492**

GENERAL BUSINESS PRACTICES	NUMBER OF CITATIONS
CCR §2695.6(b)	1
SUBTOTAL	**1**

TOTAL	501

SUMMARY OF EXAMINATION RESULTS

The following is a brief summary of the criticisms that were developed during the course of this examination related to the violations alleged in this report. This report contains only alleged violations of Section 790.03 and Title 10, California Code of Regulations, Section 2695 et al.

In response to each criticism, the Companies are required to identify remedial or corrective action that has been, or will be taken to correct the deficiency. The Companies are obligated to ensure that compliance is achieved.

Any noncompliant practices identified in this report may extend to other jurisdictions. The Companies were asked, and did not indicate, if they intend to take appropriate corrective action in all jurisdictions where applicable.

Money recovered within the scope of this report was $20,234.00 as described in sections number 9, 10 and 16 below.

LIFE

1. **In two instances, the Companies failed to provide written notice of the need for additional time or information every 30 calendar days.** In the first instance, the Company sent status update notices that failed to specify any additional information the Company requires in order to make a determination, to state any continuing reasons for the Company's inability to make a determination, and to provide an estimate as to when the determination can be made. In the second instance, the Company failed to send a status letter to a beneficiary advising of the reason for a 48 day delay in determination of coverage. The Department alleges these acts are in violation of CCR §2695.7(c)(1).

Summary of Companies' Response: The Companies acknowledge this finding and indicate that this error is not in line with company standard policies and procedures. The Company will address this issue with the individual claims staff for reinforcement and compliance training.

2. **In one instance, the Company failed to adopt and implement reasonable standards for the prompt investigation and processing of claims arising under its insurance policies.** A settlement check was issued to an incorrect payee. The Department alleges this act is in violation of CIC §790.03(h)(3).

Summary of Company Response: The Company acknowledges this finding and indicates that this error is not in line with company standard policies and procedures. The Company will address this issue with the individual claims staff for reinforcement and compliance training.

3. **In one instance each, the Companies failed to comply with the Fair Claims Settlement Practices Regulations.** The Company failed to comply with CCR §2695.3(a) -

failure to maintain all documents, notes and work papers in the claim file. In this instance, the Company has a denial letter dated July 12, 2005 in the claim file which allegedly was not sent to the claimant. However, a copy was maintained in the claim file for an unknown reason. In the second instance, the Company failed to comply with CCR §2695.7(b) – failure upon receiving proof of claim, to accept or deny the claim within 40 calendar days. Proof of claim was received on May 10, 2006. The claim was rescinded June 27, 2007, or 48 days later. The Department alleges these acts are in violation of the Fair Claims Settlement Practices Regulations.

Summary of Companies' Response: The Companies acknowledge these findings and indicate that claims handling was not in line with company standard policies and procedures. The Companies have reviewed claim documentation processes with their personnel to reinforce the importance of maintaining complete and accurate files. The failure to rescind the claim within regulatory timelines was also due to an inadvertent oversight and the pertinent claims personnel were counseled regarding this finding.

ANNUITIES

4. **In one instance each, the Companies failed to comply with the Fair Claims Settlement Practices Regulations and the California Insurance Code.** The Company failed to comply with CCR §2695.11(b) – failure to provide an explanation of benefits; CCR §2695.5(e)(2) - failure to provide necessary forms, instructions, and reasonable assistance within 15 calendar days; and CIC §790.03(h)(3) - failure to adopt and implement reasonable standards for the prompt investigation and processing of claims arising under its insurance policies. In the first instance, the Company failed to clarify the appropriate distribution of benefits among beneficiaries. In the second instance, the Company did not provide necessary forms and instructions to the claimant until 21 days after notice of claim. In the last instance, the Company generated an incorrect 1099 form and report to the Internal Revenue Services (IRS) pertaining to settlement proceeds. The Department alleges these acts are in violation of the Fair Claims Settlement Practices Regulations and the California Insurance Code.

Summary of Companies' Response: The Companies acknowledge these findings and indicate that claims handling was not in line with company standard policies and procedures. The Companies found that these were results of unintentional handling errors, and have provided further guidance to their claims staff with respect to these issues. The Companies do not believe however that these mistakes amount to a failure to adopt and implement reasonable standards for the prompt investigation and processing of claims.

ACCIDENT AND DISABILITY

5. **In 129 instances, the Companies failed to provide to the claimant an explanation of benefits including the name of the provider or services covered, dates of service, and a clear explanation of the computation of benefits.** The Companies transmitted an Explanation of Benefits (EOB) letter to the policyholder upon claim settlement which is not a clear computation or explanation of benefits. The following EOB deficiencies were noted: no provider information; missing dates of service, number of days of qualified benefits and other pertinent references; daily benefit or periodic rates not disclosed; no explanation for the methodology of calculating unscheduled benefits which should be commensurate with the operation or surgery; no explanation on Medicare offsets applied for 20 days; system limitations on the length of

characters allowed for inadequate description of benefits or plan of care; allocation and allowable percentage of benefits payable on actual services were not disclosed; clerical processing errors in inputting information such as pertinent dates of service; application of rider benefits, bonus benefits and maximum payouts (limits) are not explained; re-pricing of billed charges according to non-existent policy contract rate agreement and references to non-insurance discount programs; for one or more surgeries, surgery benefits are not distinctively described or clarified; line items or incurred amounts were missing, or invoice items were not properly matched on the EOB; rejected, denied and 'bundling' of charges were not explained or listed; specific charges were batched with a general description of benefits; and other unpaid invoice charges were not acknowledged as to their disposition in the EOB. The Department alleges these acts are in violation of CCR §2695.11(b).

Summary of Companies' Response: The Companies disagree with the Department's findings. It is the Companies' position that the regulation does not elaborate upon, or define the terminology of 'a clear explanation of the computation of benefits'. The Companies assert that there is no format prescribed by the law to assure compliance with this section of the regulation. The Companies believe it is in compliance with California law.

The Companies further stated that they, "have not received indications from its insureds that its explanation of benefits (EOB) forms are insufficient or unclear, nor have their insureds expressed confusion as to whether previously-handled claims have been completely resolved. Therefore, the details set forth in the Companies' explanation of benefits (EOBs) supplies ample information for insureds regarding the handling of their respective claims".

While the Companies believe that their EOBs are sufficient, they have offered to make some changes in their EOB formats. In the category of Long-Term Care, United American Insurance Company through its McKinney, Texas claims administration, indicates that it will create a new "remark code" which will be added to all EOBs for Long Term Care policies when invoices submitted reflect additional charges that are not covered expenses under the policy. The additional remark will state, "This payment represents the total daily benefit available for each day confined during this period. Your policy does not provide separate benefits for other services that might be itemized on the nursing home bill, such as charges for telephone, radio or television, extra beds or cots, wheelchair, (to be specified)...". Another remark code option added by the McKinney claims administration is "This long term care policy pays for expenses actually incurred, up to the daily benefit limits as stated in the policy. If the expense actually incurred is less than the daily benefit limit, then the amount paid under the policy will be no greater than the expense incurred".

American Income Life through its Waco, Texas claims administration also indicates that the EOBs on its disability/health claims which are provided to each claimant will be expanded. They will include the daily, weekly, or monthly rate at which benefits are paid for hospital confinement or disability/recuperation, and will include reference when the maximum benefit is reached.

Examiner Response: This remains an unresolved issue and may result in further administrative action.

6. **In 100 instances, the Companies failed to disclose all benefits, coverage, time limits or other provisions of the insurance policy.** The Companies were inconsistent in disclosure of all benefits, coverage and policy provisions that may apply when a claim is presented by the claimant. This includes applicable coverage such as daily or periodic benefit rates for various levels of care, elimination period, waiver of premium benefits, maximum benefit periods, prescription drug benefits, 10% bonus and inflation benefit riders and other provisions affecting the determination of benefits. The Department alleges these acts are in violation of CCR §2695.4(a).

Summary of Companies' Response: The Companies disagree that they have any obligation to disclose benefits, coverage, and provisions of the policy to its policyholders when a claim has been presented. It is the Companies' position that the insureds should refer instead to their own policy copies which was provided to them at the time the policy was issued.

However, in October 2007, American Income Life Insurance Company through its Waco, Texas claims unit began providing all claimants with a Disclosure of Benefits letter that details the benefits available under the policy contract and includes the benefit amounts and the maximum limits payable for each coverage item.

Examiner Response: This remains an unresolved issue and may result in further administrative action.

7. **In 87 instances, the Companies failed to include a statement in its claim denial that, if the claimant believes the claim has been wrongfully denied or rejected, he or she may have the matter reviewed by the California Department of Insurance.** The Department alleges these acts are in violation of CCR §2695.7(b)(3).

Summary of Companies' Response: The Companies acknowledge these findings and indicate that it is their Companies' policy to include the California Department of Insurance contact reference with each denied claim. American Income Life Insurance Company through its Waco, Texas claims administration indicates that it has corrected its systems programming in January 2006 so that all notices of denial now include the required language. In October 2007, AILIC also began providing all claimants with a Disclosure of Benefits letter which contains the CDI denial language.

UAIC and GLAIC state that an EOB that does not address each and every item of a billing does not constitute a claim denial and therefore does not require the CDI denial language.

Examiner Response: This remains an unresolved issue and may result in further administrative action.

8. **In 85 instances, the Companies failed to provide the written basis for the denial of the claims.** The Companies failed to provide the written basis for a full or partial denial of the claims. The Companies did not provide a legal basis for the denial, failed to address the specific charges that were being denied and/or failed to send a denial notice to the insured. The examiners identified 24 instances of a variety of submitted charges such as prosthetic devices, and ambulance charges that were not paid. However, there was no written basis for the denial of these charges. In 16 instances paid charges/limits did not match actual submitted charges. In the

other 45 instances, denial notices were not sent when diagnostic procedures and services such as office visits, therapy and room charges were not paid. The Department alleges these acts are in violation of CCR §2695.7(b)(1).

Summary of Companies' Response: The Companies' response in 16 of the instances is that "the additional charges on the bills submitted were not denied; rather the eligible benefits were paid per policy terms". The Companies' response in 26 of the instances is that the EOB includes the following statement, "Only those charges that are eligible for benefits have been considered. All other charges are not covered under the terms of the policy". In the 43 other instances, the Companies disagree that they failed to provide a legal basis for the denial, or failed to send a denial letter on pertinent charges presented. The Companies state the policies in question are limited benefit policies, not comprehensive or major medical policies. Therefore, they explained it is not necessary to address in a written denial each billed charge they deem ineligible for payment.

Examiner Response: This remains an unresolved issue and may result in further administrative action.

9. **In 32 instances, the Companies attempted to settle a claim by making a settlement offer that was unreasonably low.** The Companies underpaid and/or failed to pay benefits under Surgical, Cancer, Long-Term Care, and Income Disability policies. The following summarizes the examiners' findings:

a) In seven instances, the Companies failed to pay qualified cancer benefits and defined benefits such as EKG, hypodermics, drugs, surgical dressings and supplies, and anesthesia.

b) In five instances, the Companies did not pay for all pertinent surgical supplies under their policy. It is AILIC's procedure to pay only for surgical dressings and supplies limited to the date of the surgery only. This restrictive policy is self-imposed by AILIC and is not in conformity with the policy provisions. There were no limitations or restrictions on the policy to support AILIC's interpretation and settlement of these specific benefits.

c) In four instances, there was either a miscalculation or non-payment of surgical benefits and procedures.

d) In three instances, there was an underpayment of disability benefits.

e) In two instances, the Companies failed to pay other eligible benefits such as surgical benefits, anesthesia, laboratory, x-rays, medicines and 10% bonus.

f) In two instances, invoice items were not paid pursuant to Use of Lung Benefits.

g) In two instances, room charges were not paid under Long-Term Care benefits.

h) In two instances, the Companies did not pay the maximum limits on EKG and antibiotics.

i) In one instance each, the Companies did not pay for physician call charges, miscalculated unscheduled surgery benefits, failed to issue Good Risk Benefits discount on a cancer policy, used incremental payment of $5 or $10 in non-scheduled benefits instead of actual charges, and incorrectly bundled benefits for a lower settlement amount.

The Department alleges these acts are in violation of CCR §2695.7(g).

Summary of Companies' Response: The Companies acknowledge that these claims were improperly paid. As a result of these findings, a total amount of $ 18,911.28 was paid to policyholders/claimants identified within the examination samples.

However, on item #b above, the Companies disagree with the Department's findings and believe they have correctly applied benefits limited to the date of surgery only. The Companies indicate that the exception to this limitation would be "dressings" on wounds which may need to be replaced after the date of surgery.

Under the Companies' HGF policy Part I Hospital Expense Benefits, if an insured is necessarily confined within a hospital as a resident patient on account of such injury or such sickness, the Company will pay the hospital expense actually incurred, but not to exceed the regular and customary charges stated under Surgical Dressings and Supplies.

The Companies interpret this to mean "surgical dressings used throughout the hospital confinement to dress the wound, and supplies used for surgery only" therefore any supplies used on any date of confinement other than the date of surgery would not qualify as a surgical supply. The Companies do not agree that all surgical supplies and dressing used throughout the hospital confinement qualify for benefits under this category. It is the Companies' position that their interpretation of surgical supplies mean only those supplies used during the actual performance of the surgery and will qualify only supplies used on the date of the surgery, not those used during the entire confinement due to surgery.

Examiner Response: This remains an unresolved issue and may result in further administrative action.

10. In 26 instances, the Companies failed to effectuate prompt, fair and equitable settlements of claims in which liability had become reasonably clear. The examiners found the following exceptions in their review of claims:

a) In 16 instances, actual charges including room and board charges were "re-priced" and/or discounted ten to twenty percent without substantiation. UAIL contracts with two vendor companies administer a non-insurance discount program on health services for policyholders who purchase non-Medicare supplement health insurance policies. However, all the Companies utilize one of these vendors for "re-pricing" of services instead of paying the usual and customary charges pursuant to the policy contract provisions. If the re-pricing information is not available with the two contracted vendors, the Companies use a non-contracted vendor's discount information in claims processing.

b) In five instances, valid charges submitted by claimants were deemed ineligible as "covered benefits" by the Companies.

c) In one instance each, the Companies utilized an internet search to estimate the value of an implant device in lieu of paying the usual and customary charges; delayed the application of the waiver of premium (WOP) on a long-term care policy; omitted two weeks of eligible services by imposing an incorrect maximum limit; did not pay or issue Good Risk provision benefit in an Individual Health Cancer policy; and did not verify a Medicare Remittance Summary Notice to validate Medicare offsets to reduce benefits on Long-Term Care claims by at least 20 days.

The Department alleges these acts are in violation of CIC §790.03(h)(5).

Summary of Companies' Response: The Companies agree that two of the 31 violations were inadvertent processing mistakes on the part of its adjusters. The Companies issued additional monies to claimants in the amount of $834.53 and will counsel the individual payment processors.

The Companies dispute the remaining findings and maintain that they are in compliance with regulations. The Companies disagree that the informal discounts provided by these non-insurance programs should include an explanation that an out-of-pocket expense as a result of the discount is not the responsibility of the insured.

With regard to the Medicare offsets, UAIC applies its knowledge of Medicare payment patterns when reviewing bills received from a skilled nursing facility and does not believe it is necessary to validate offsets by securing copies or verifying Medicare remittances. In the instances cited, UAIC contends the pattern of Medicare is to pay the first 20 days at one-hundred percent, therefore Long-Term Care benefits were reduced.

Examiner Response: This remains an unresolved issue and may result in further administrative action.

11. In 14 instances, the Companies failed to maintain all documents, notes and work papers in the claim file. The claim files were missing copies of denial letters, Medicare Remittance Summary/Advice, supporting Medicare offsets, copy of application and the declaration page of policies for verification of benefits. The Department alleges these acts are in violation of CCR §2695.3(a).

Summary of Companies' Response: The Companies acknowledge that communication letters, invoices, worksheets, and other claim documents were missing from claim files. Furthermore, the Companies acknowledge they were unable to reproduce copies of their application records as they had been "purged". The Companies state that they began transitioning their paper "hard copy" filing systems to electronic "scanned image" filing systems and may have accidentally lost some records during the examination window period. The Companies have now fully transitioned to electronic scanned image filing systems and do not expect to have further issues related to lost or missing documents. Nonetheless, the Companies have reminded their respective document imaging departments to capture all documents at the time of scanning.

12. **In four instances, the Companies failed to adopt and implement reasonable standards for the prompt investigation and processing of claims arising under its insurance policies.** The Companies: (a) did not have a procedure in place to investigate and validate medical charges; (b) and (c) placed two claims on its pending list for 16 months and 8 months respectively without monitoring, follow-up, or appropriate closure procedures; and (d) failed to investigate and expedite payment of claim – a 58 day gap in file activity occurred. The Department alleges these acts are in violation of CIC §790.03(h)(3).

Summary of Companies' Response: The Companies acknowledge delay issues as noted above and have discussed the claims with the pertinent examiners who handled them. However, the Companies maintain that their procedure to secure general pricing information using a general internet search is appropriate and acceptable as this may be considered as "usual and customary" charges. The Companies indicate they could not retrieve cost information related to the particular implant components and therefore used the internet referencing "typical" rather than specific implant component costs.

Examiner Response: This remains an unresolved issue and may result in further administrative action.

13. **In five instances, the Company failed to conduct and pursue a thorough, fair and objective investigation of a claim.** These acts include: three instances wherein the Company required the insured (1) to secure claim information such as the surgical procedure code, (2) to produce a written verification of the hospital facilities requirement, and (3) to secure manufacturer and model information on prosthetic devices. Although the actual model number and manufacturer information were later provided to the Company in this third instance, it did not use usual and customary charges to settle the claim but used general information from the internet for pricing. As a result, the Companies withheld payment for hospital confinement benefits and failed to use accurate information to settle the usual and customary charges. In another instance, the Company utilized a general "internet" search without matching the appropriate information on prosthetic devices such as the model number, manufacturer, geographic or territorial information, and other pertinent search parameters. This general "internet" search resulted in differences in actual payments from actual billed charges. In the last instance, the Company failed to contact the provider or secure a medical authorization. As a result, medical charges in excess of $30,000 were not considered for payment. The Department alleges these acts are in violation of CCR §2695.7(d).

Summary of Company Response: AILIC acknowledges these findings and has counseled its claims examiner regarding its claims-handling processes including the verification of provider licensee information. The Company disagrees that it has the responsibility to assist the insured in obtaining additional provider invoices in two of the instances. The Company maintains that its procedure to secure general pricing information using a general internet search in two instances is appropriate and acceptable as an internet source may be considered as "usual and customary" charges.

Examiner Response: This remains an unresolved issue and may result in further administrative action.

14. **In four instances, the Companies failed to represent correctly to claimants, pertinent facts or insurance policy provisions relating to a coverage at issue.** In two instances, EOBs on Long-Term Care included an inaccurate statement that policy benefits are to be reduced by Medicaid payments. This information contradicts the actual policy language which excludes Medicaid payments from any offsets. In one instance, a statement in a denial letter indicated that none of the special services were rendered for the treatment of cancer therefore no benefits were payable under the policy. However, the treatment of the bladder tumor qualified as a scheduled benefit under the policy. In the last instance, the policyholder was advised that the maximum period had been reached and maximum limits exhausted on a policy as of December 19, 2005. Actual benefits were not set to expire until February 25, 2006. The Department alleges these acts are in violation of CIC §790.03(h)(1).

Summary of Companies' Response: The Companies acknowledge these findings and attribute them to examiner error which has been addressed on a case by case basis with the claims associates. With regard to the programmed remark codes on Medicaid, the Companies agree this was incorrect language and will change its EOB codes to reflect "including Medicare, but excluding Medicaid". The incorrect remark code was an oversight. The Companies further explained that there was no harm done as nothing was owed to the claimant.

15. **In two instances, the Companies failed to provide necessary forms, instructions, and reasonable assistance within 15 calendar days.** In one instance, the Company failed to send a medical authorization to the insured in order to secure the necessary information from the provider and pay the claim. In the second instance, the Company received an initial invoice of over $99,000 on October 26, 2005 but did not request additional information or provide claims instructions to the insured until November 15, 2005. The Department alleges these acts are in violation of CCR §2695.5(e)(2).

Summary of Companies' Response: The Companies acknowledge there were inadvertent mistakes made that have been addressed on a case by case basis with its claims associates.

16. **In two instances, the Companies failed, upon acceptance of the claim, to tender payment within 30 calendar days.** In two separate instances, the Companies failed to pay hospital confinement benefits and emergency accident benefits within regulatory timelines. The Department alleges these acts are in violation of CCR §2695.7(h).

Summary of Companies' Response: The Companies acknowledge these were inadvertent errors and issued additional monies owed to claimants in the amount of $488.19. These criticisms were addressed with AILIC claims-handling personnel in order to improve future claim processing efficiencies.

17. **In one instance, the Company failed to respond to communications within 15 calendar days.** The communications to the Company included a policyholder's inquiry regarding benefits. However, the Company did not respond to this inquiry within the prescribed time limit. The Department alleges this act is in violation of CCR §2695.5(b).

Summary of Company Response: The Company disagrees with the examiner as it believes the policyholder's communication did not require a response. However, AILIC will remind its claims examiners to address all aspects of an insured's correspondence.

18. **In one instance, the Company failed to maintain claim data that are accessible, legible and retrievable for examination.** One claim file was missing and was not presented to the Department for examination. The Department alleges this act is in violation of CCR §2695.3(b)(1).

Summary of Company Response: The Company acknowledges it was unable to locate a claim file. This is an isolated case and is not reflective of the Company procedure on maintenance of electronic records.

GENERAL BUSINESS PRACTICES

19. **The Company failed to provide thorough and adequate training regarding these regulations to all its claims agents.** The claims personnel from the Alabama and McKinney, Texas claims units for Globe Life and Accident Insurance Company did not have California claims training for the years 2004 and 2005. The Department alleges these acts are in violation of CCR §2695.6(b).

Summary of Company Response: The Company acknowledges it did not have formal California claims training, however it believes that regular training from their team leads, supervisors and managers was sufficient. The Company emphasized "hands-on" training does occur on a day-to-day basis as examiners have frequent interaction with their supervisors and their department manager creating an ongoing discourse and discussion regarding claims processes and procedures. All personnel will be trained on California regulations annually on a moving-forward basis.